

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 09/12/2013
FORM APPROVED
OMB NO. 0938-0391

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|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E242 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 09/12/2013 | |
| NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL ONAGA LTCU | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENTS | | | F 000 | | | |
| F 157 SS=D | <p>The following citations represent the findings of a Health Resurvey.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 33 residents. The</p> | | | F 157 | | | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | | | TITLE | | (X6) DATE | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 157 | <p>Continued From page 1</p> <p>sample included 14 residents. Based on observation, record review and interview, the facility failed to notify the physician for 1 of 14 sampled residents, who had a change in his/her status. (#38)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #38's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 5/15/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 13, which indicated intact cognition. The MDS indicated the resident was independent with bed mobility, transfers, walking, locomotion and eating, and his/her balance was not steady. <p>The 5/16/13 care plan indicated the resident was independent with transfers.</p> <p>The 5/23/13 at 5:50 PM, nurse's notes revealed the resident came in from the patio, sat down to eat and when the staff gave the resident his/her medications, his/her skin was very pale, cool and clammy and his/her lips were white in color. Staff transferred the resident to his/her room, he/she was able to stand to transfer from the wheelchair to the bed, and the resident's vitals signs were: temperature 97.6, pulse 58, respirations 20, blood pressure 63/41, and oxygen saturation 97% on room air.</p> <p>The 5/23/13 at 6:20 PM, nurse's notes revealed the resident's vital signs were: blood pressure 86/35, pulse 70, oxygen saturation 95%, the resident's skin was cool and not as clammy, he/she was alert and still able to transfer, without difficulty, to the bed.</p> <p>The 5/23/13 at 7:15 PM, nurse's notes revealed</p> | F 157 | | | |

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| F 157 | <p>Continued From page 2</p> <p>the resident's vital signs were: blood pressure 120/63 and pulse 68 and the resident was resting quietly.</p> <p>The 5/24/13 at 4:00 AM, nurse's notes stated at 2:30 AM, another resident rang the call light and let the staff know the resident was lying on the floor. Upon entering the bathroom, staff found the resident lying on the floor in front of the toilet. The resident's brief was around his/her knees and the resident was propping himself/herself up with one arm. There was blood on the floor and on the right side of the resident's face. The staff cleansed the blood from the resident's face, no active bleeding was noted, and the right eye had bruising and swelling both above and below the eye. Upon examination of the resident's eye, a small lens with 2 blue extensions was noted on the resident's lower eyelid. When the resident opened his/her eye, a moderate amount of bloody drainage came from the resident's eye and upon closure of the eye, the resident complained of pain. The resident was later transported from the facility to a hospital where he/she underwent surgery to his/her right eye for a ruptured globe and corneal laceration.</p> <p>On 9/4/13 at 3:52 PM, observation revealed the resident propelled himself/herself around the facility in a wheelchair and visited with the staff and other residents.</p> <p>On 9/9/13 at 11:21 AM, Administrative Nurse F stated per the facility's protocol, the staff should have called the physician after the 63/41 blood pressure was obtained.</p> <p>Review of the facility's 7/8/10 Blood Pressure and Pulse Parameters policy directed the staff to notify the health care provider if the systolic blood</p> | F 157 | | | |

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| F 157 | Continued From page 3 pressure is <80 or >190 and the diastolic blood pressure is <40 or >110. The facility failed to notify Resident #38's physician after a significant change in physical status. | F 157 | | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility had a census of 33 residents. The sample included 14 residents, of which 2 were reviewed for accidents. Based on record review, interview and observation the facility failed to develop a comprehensive plan of care to prevent further falls for 1 of 2 sampled residents. (#29) Findings included: | F 279 | | | |

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| F 279 | <p>Continued From page 4</p> <p>- Review of the medical record revealed Resident #29 was admitted to the facility on 6/25/13.</p> <p>Resident #29's admission (MDS) Minimum Data Set 3.0 assessment, dated 7/4/13, indicated the resident had adequate vision with glasses and moderately impaired decision making skills. The MDS indicated the resident required total staff assistance with all (ADLs) Activities of Daily Living, except eating. The MDS indicated the resident had unsteady balance, a history of falls and impaired (ROM) Range of Motion in all extremities.</p> <p>The 7/4/13 (CAAs) Care Area Assessment summary for falls indicated the resident had fallen prior to admission, had balance problems and was not able to stand or walk. The summary indicated the resident was transferred per stand up lift and 2 staff assistance and received medications that can cause balance issues and dizziness.</p> <p>The 6/25/13 Fall Risk assessment indicated the resident was at high risk for falls.</p> <p>Review of the resident's 7/9/13 comprehensive care plan revealed no fall care plan to direct the staff for care interventions to prevent falls or further interventions after the resident's falls on 8/16, 8/17, and 8/18/13.</p> <p>The 8/16/13 at 3:15 PM, nurse's note indicated the staff found the resident seated on the floor in his/her room with no apparent injuries.</p> <p>The 8/17/13 at 8:00 PM, nurse's note indicated staff found the resident on the floor in his/her</p> | F 279 | | | |

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| F 279 | Continued From page 5 room with no apparent injuries. The 8/18/13 at 8:50 AM, nurse's note indicated the staff were with the resident, who was sitting on the side of the bed, and the staff attempted to use the sit to stand lift to transfer the resident. The note indicated the resident pushed the lift away, the resident started to slide and the staff lowered him/her to the floor. On 9/4/13 at 2:43 PM, observation revealed the resident, seated in a recliner, in the commons area and staff talking to him/her. Further observation revealed the resident wore non-skid socks and had glasses on. On 9/5/13 at 2:50 PM, Nurse Aide G stated the resident was able to position him/herself on the side of the bed, but the resident's legs do not support him/her well enough to stand. Nurse Aide G stated the resident sometimes attempted to stand without staff assistance. On 9/9/13 at 1:50 PM, Nurse A verified the resident had fallen prior to admission to the facility and had fallen 3 times in the facility. He/She verified the facility lacked a care plan to prevent falls for the resident. The facility failed to develop and implement a comprehensive plan of care for Resident #29, who had a history of falls, and had 3 additional falls after admission to the facility. | F 279 | | | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the | F 314 | | | |

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| F 314 | <p>Continued From page 6</p> <p>individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 33 residents. The sample included 14 residents of which 2 were reviewed for pressure ulcers. Based on record review, interview and observation the facility failed to assess pressure ulcers weekly for 2 of 2 sampled residents. (#18, #40)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #18's admission (MDS) Minimum Data Set 3.0 assessment, dated 7/24/13, indicated the resident had intact cognition and was independent with decision making skills. The MDS indicated the resident required extensive staff assistance with toileting and hygiene, limited staff assistance with dressing, and supervision or independent with all other (ADLs) Activities of Daily Living. The MDS indicated the resident was at risk for pressure ulcers, had three Stage 2 (skin open to the 2nd layer) pressure ulcers and interventions included pressure relief devices for the chair and bed, nutrition, ulcer care, dressings and ointments. <p>The 7/25/13 (CAAs) Care Area Assessment summary indicated the resident had three Stage 2 ulcers on admission and he/she was at risk due to a mobility problem and incontinence.</p> <p>The 7/25/13 care plan directed the staff to provide a regular diet and Prosource (a nutritional supplement), one ounce, twice daily, for wound</p> | F 314 | | | |

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| F 314 | <p>Continued From page 7</p> <p>healing. The care plan indicated the resident had Stage 2 dermal ulcers on his/her buttocks and on the right great toe. The care plan further directed the staff to encourage the resident to reposition every 2 hours or more often, provide a dietary and physician consult as needed, encourage adequate food and fluid intake and increased protein intake. The care plan further directed the staff to provide a pressure reducing mattress, document size of the pressure ulcers and observe for signs of infection.</p> <p>The 7/16/13 Admission Skin Assessment for Breakdown indicated the resident was at moderate risk for pressure ulcers.</p> <p>The 7/16/13 Admission Skin Assessment indicated the resident had the following skin conditions:</p> <ol style="list-style-type: none"> 1) 2 open areas on the buttocks measuring 1 x 3 (cm) centimeters and 1.5 x 1 cm. 2) an open area on the right great toe measuring 0.25 x 0.25 cm surrounded by white skin. The Admission Skin Assessment indicated the staff would assess and document the open areas weekly. <p>The Weekly Documentation for the right great toe included the following:</p> <ol style="list-style-type: none"> 1) 8/4/13 - 0.3 x 0.2 cm, no drainage. (15 days after the initial assessment) 2) 8/14/13 - 0.25 x 0.25 cm area healing slowly. (10 days between assessments) 3) 8/23/13 - 0.3 x 0.3 x 0.1 cm, scant drainage. (9 days after the last assessment) 4) 9/6/13 - 0.25 x 0.25 cm no drainage. (14 days after the last assessment) <p>On 9/9/13 at 2:38 PM, Nurse B observed the resident's foot wounds. The right great toe had an</p> | F 314 | | | |

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| F 314 | <p>Continued From page 8</p> <p>approximately 1 cm diameter open area. Nurse B stated the Prism dressing was in there, with Vaseline gauze over the small open area, 4 x 4 gauze over all and taped on.</p> <p>On 9/9/13 at 11:15 AM, Nurse B verified the wound record lacked weekly documentation of the resident's pressure ulcers.</p> <p>The facility's 11/2003 Wound and Skin Protocol for Pressure Ulcers stated if skin breakdown is identified, the staff will provide weekly monitoring, unless otherwise directed by the physician, and contact the physician immediately, when identifying wound and skin problems.</p> <p>The facility failed to thoroughly assess and document Resident #18's open areas weekly, to monitor healing and/or the need for further interventions.</p> <p>- Resident #40's admission (MDS) Minimum Data Set 3.0 assessment, dated 7/31/13, indicated the resident had intact cognition. The MDS indicated the resident was independent with most (ADLs) Activities of Daily Living and required supervision with dressing, toileting and hygiene. The MDS indicated the resident was at risk for pressure ulcers and had one Stage 2 skin (open to the 2nd layer) pressure ulcer, which was present on admission. Interventions included a pressure relief device in the chair, ulcer care, dressings and ointments.</p> <p>The 8/1/13 (CAAs) Care Area Assessment summary indicated the resident had a pressure ulcer, for several months, on his/her left 3rd toe which measured 0.25 x 0.25 (cm) centimeter,</p> | F 314 | | | |

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| F 314 | <p>Continued From page 9 with no presence of eschar or slough.</p> <p>The 8/1/13 care plan directed the staff to provide a regular diet, offer alternatives, high protein snacks between meals and consult the dietician on admission and as needed. The care plan further directed the staff to encourage the resident to reposition every 2 hours or more often, encourage adequate food and fluid intake and increase protein intake.</p> <p>The 7/24/13 Admission Skin Breakdown Assessment indicated the resident was at moderate risk for skin breakdown. The temporary plan of care on the assessment indicated the staff were to monitor and document the resident's open areas weekly.</p> <p>The Weekly Documentation included the following measurements of the open area on the resident's left foot, 3rd toe:</p> <ol style="list-style-type: none"> 1) 7/24/13 - 0.25 x 0.25 cm. 2) 8/3/13 - 0.5 x 0.5 cm, no drainage. (10 days after the ulcer was noted on admission) 3) 8/14/13 - 0.5 x 0.5 cm. (11 days after the last assessment) 4) 8/23/13 - no open area. (9 days after the last assessment) <p>On 9/5/13 at 7:45 AM, observation revealed the resident seated on the side of the bed, with no shoes on. Nurse B observed the resident's left 3rd toe, which was not open and had a callous approximately 1 x 1 cm, pink in color.</p> <p>On 9/9/13 at 2:30 PM, Nurse A verified the staff had not documented the weekly skin assessments for the resident's left 3rd toe, per facility protocol.</p> | F 314 | | | |

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| F 314 | Continued From page 10 The facility's 11/2003 Wound and Skin Protocol for Pressure Ulcers stated if skin breakdown is identified, the staff will provide weekly monitoring, unless otherwise directed by the physician, and contact the physician immediately, when identifying wound and skin problems. . The facility failed to assess the skin and open areas weekly, as care planned for Resident #40, who was at moderate risk for skin breakdown. | F 314 | | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 33 residents. The sample included 14 residents, of which 2 were reviewed for accidents. Based on record review, interview and observation the facility failed to provide supervision and assistive devices to prevent further falls for 1 of 2 sampled residents. (#29) Findings included: - Review of the medical record revealed Resident #29 was admitted to the facility on 6/25/13. Resident #29's admission (MDS) Minimum Data Set 3.0 assessment, dated 7/4/13, indicated the resident had adequate vision with glasses and | F 323 | | | |

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| F 323 | <p>Continued From page 11</p> <p>moderately impaired decision making skills. The MDS indicated the resident required total staff assistance with all (ADLs) Activities of Daily Living, except eating. The MDS indicated the resident had unsteady balance, a history of falls and impaired (ROM) Range of Motion in all extremities.</p> <p>The 7/4/13 (CAAs) Care Area Assessment summary for falls indicated the resident had fallen prior to admission, had balance problems and was not able to stand or walk. The summary indicated the resident was transferred per stand up lift and 2 staff assistance and received medications that can cause balance issues and dizziness.</p> <p>The 6/25/13 Fall Risk assessment indicated the resident was at high risk for falls.</p> <p>Review of the resident's 7/9/13 comprehensive care plan revealed no fall care plan to direct the staff for care interventions to prevent falls or further interventions after the resident's falls on 8/16, 8/17, and 8/18/13.</p> <p>The 8/7/13 at 8:00 PM, nurse's note indicated staff found the resident on the floor in his/her room with no apparent injuries.</p> <p>The 8/16/13 at 3:15 PM, nurse's note indicated the staff found the resident seated on the floor in his/her room with no apparent injuries.</p> <p>The 8/18/13 at 8:50 AM, nurse's note indicated the staff were with the resident, who was sitting on the side of the bed, and the staff attempted to use the sit to stand lift to transfer the resident. The note indicated the resident pushed the lift away, the resident started to slide and the staff</p> | F 323 | | | |

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| F 323 | <p>Continued From page 12 lowered him/her to the floor.</p> <p>On 9/4/13 at 2:43 PM, observation revealed the resident, seated in a recliner, in the commons area and staff talking to him/her. Further observation revealed the resident wore non-skid socks and had glasses on.</p> <p>On 9/5/13 at 2:50 PM, Nurse Aide G stated the resident was able to position him/herself on the side of the bed, but the resident's legs do not support him/her well enough to stand. Nurse Aide G stated the resident sometimes attempted to stand without staff assistance.</p> <p>On 9/9/13 at 1:50 PM, Nurse A verified the resident had fallen prior to admission to the facility and had fallen 3 times in the facility. He/She verified the facility lacked a care plan to prevent falls for the resident.</p> <p>The facility failed to implement supervision and assistive devices to prevent further falls for Resident #29, who had a history of falls and experienced 3 additional falls after his/her admission to the facility.</p> | F 323 | | | |
| F 329 SS=D | <p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a</p> | F 329 | | | |

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| F 329 | <p>Continued From page 13</p> <p>resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 33 residents. The sample included 14 residents of which 5 were reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to ensure 2 of the 5 sampled resident's drug regimens were free from unnecessary medications. (#6 and #12)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #6's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 8/7/13, indicated the resident had short and long term memory problems, moderately impaired cognition, and received scheduled insulin, antipsychotic, antidepressant, and diuretic medications. <p>The 8/7/13 care plan directed the staff to administer Seroquel (an antipsychotic) at noon and bedtime.</p> <p>Review of the 8/2/13 physician's orders directed the staff to administer Seroquel XR, 100 (mg) milligrams, daily at noon (initiated 3/9/12) and 400</p> | F 329 | | | |

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| F 329 | <p>Continued From page 14 mg, daily every PM (initiated 6/11/10).</p> <p>Review of the resident's medical record and facility's pharmacist consultant reviews since 8/1/12, revealed no gradual dosage reduction attempt or recommendation to reduce the resident's use of the Seroquel medication.</p> <p>On 9/5/13 at 12:12 PM, observation revealed the resident, seated at the dining room table, eating lunch independently.</p> <p>On 9/9/13 at 9:23 AM, Administrative Nurse F stated the facility did not attempt a gradual dose reduction in the last year for the resident's Seroquel.</p> <p>The facility failed to review Resident #6's psychotropic medication for gradual dosage reduction.</p> <p>- Resident #12's annual (MDS) Minimum Data Set 3.0 assessment, dated 8/7/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 15, which indicated intact cognition. The MDS also indicated the resident required extensive assistance of 2 staff with bed mobility, transfers, walking in the room/corridor, and received scheduled insulin, antidepressant, anticoagulant, and diuretic medications.</p> <p>The 8/7/13 care plan directed the staff to obtain a blood laboratory (PT) protime (a blood test that measures how long it takes blood to clot) monthly.</p> <p>The 8/1/13 physician's orders directed the staff to administer Warfarin (a blood thinner) 3.5 (mg) milligrams, daily, and obtain a (PT/INR) Pro-thrombin Time/Internationalized Ratio</p> | F 329 | | | |

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| F 329 | Continued From page 15 monthly. Review of the resident's medical record revealed the resident did not receive a PT for the months of May and July 2013. On 9/4/13 at 3:40 PM, observation revealed the resident, seated in a recliner in his/her room, watching television. On 9/9/13 at 9:19 AM, Administrative Nurse F verified the facility did not obtain a PT from the resident for May or June 2013. Review of the Medication Monitoring Guidelines policy, dated 6/11/01, directed the staff to obtain a monthly serum pro-thrombin time (PT), unless the physician ordered differently, for residents who received Warfarin and to contact the physician with the results, whether normal or abnormal. The facility failed to monitor the effectiveness of Resident #12's blood thinner medication. | F 329 | | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility had a census of 33 residents. The | F 428 | | | |

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| F 428 | <p>Continued From page 16</p> <p>sample included 14 residents of which 5 were reviewed for unnecessary medications. Based on observation, record review and interview, the facility's pharmacist consultant failed to report to the director of nursing, or the physician, drug irregularities for 2 of the 5 sampled resident's. (#6 and #12)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #6's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 8/7/13, indicated the resident had short and long term memory problems, moderately impaired cognition, and received scheduled insulin, antipsychotic, antidepressant, and diuretic medications. <p>The 8/7/13 care plan directed the staff to administer Seroquel (an antipsychotic) at noon and bedtime.</p> <p>Review of the 8/2/13 physician's orders directed the staff to administer Seroquel XR, 100 (mg) milligrams, daily at noon (initiated 3/9/12) and 400 mg, daily every PM (initiated 6/11/10).</p> <p>Review of the resident's medical record and facility's pharmacist consultant reviews since 8/1/12, revealed no gradual dosage reduction attempt or recommendation to reduce the resident's use of the Seroquel medication.</p> <p>On 9/5/13 at 12:12 PM, observation revealed the resident, seated at the dining room table, eating lunch independently.</p> <p>On 9/10/13 at 8:21 AM, Administrative Nurse F stated the pharmacist consultant had not addressed the lack of a gradual dosage reduction for the resident's Seroquel.</p> | F 428 | | | |

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| F 428 | <p>Continued From page 17</p> <p>The facility's pharmacist consultant failed to identify and address the need for a gradual dose reduction of Resident #6's Seroquel, a psychotropic medication.</p> <p>- Resident #12's annual (MDS) Minimum Data Set 3.0 assessment, dated 8/7/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 15, which indicated intact cognition. The MDS also indicated the resident required extensive assistance of 2 staff with bed mobility, transfers, walking in the room/corridor, and received scheduled insulin, antidepressant, anticoagulant, and diuretic medications.</p> <p>The 8/7/13 care plan directed the staff to obtain a blood laboratory protime (PT) (a blood test that measures how long it takes blood to clot) monthly.</p> <p>The 8/1/13 physician's orders directed the staff to administer Warfarin (a blood thinner) 3.5 (mg) milligrams, daily, and obtain a (PT/INR) pro-thrombin time monthly.</p> <p>Review of the resident's medical record revealed the facility did not obtain a (PT) protime for the months of May and July 2013.</p> <p>Review of the facility's Pharmacist Consultant reviews for June, July and August revealed no documentation regarding the lack of a (PT) protime for the resident.</p> <p>On 9/4/13 at 3:40 PM, observation revealed the resident, seated in a recliner in his/her room, watching television.</p> | F 428 | | | |

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| F 428 | <p>Continued From page 18</p> <p>On 9/10/13 at 8:21 AM, Administrative Nurse F stated the pharmacy consultant did not address the omission of the resident's May and July protimes.</p> <p>Review of the Medication Monitoring Guidelines policy, dated 6/11/01, directed the staff to obtain a monthly serum pro-thrombin time (PT), unless the physician ordered differently, for residents who received Warfarin and to contact the physician with the results, whether normal or abnormal.</p> <p>The facility's pharmacist consultant failed to address the facility's lack of monitoring the effectiveness of Resident #12's blood thinner.</p> | F 428 | | | |